COMMITTEE REPORT

MR. PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1749, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, between lines 20 and 21, begin a new paragraph and insert:

"SECTION 2. IC 12-15-35-28, AS AMENDED BY P.L.107-2002, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 28. (a) The board has the following duties:

(1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.

(2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(3) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the

compendia and developed with professional input with provisions for timely revisions and assessments as necessary.

(4) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.

(5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year.

(6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:

(A) The Indiana board of pharmacy.

(B) The medical licensing board of Indiana.

(C) The SURS staff.

(7) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.

(B) Potential or actual severe or adverse reactions to drugs.

(C) Therapeutic appropriateness.

(D) Overutilization or underutilization.

(E) Appropriate use of generic drugs.

(F) Therapeutic duplication.

(G) Drug-disease contraindications.

(H) Drug-drug interactions.

(I) Incorrect drug dosage and duration of drug treatment.

(J) Drug allergy interactions.

(K) Clinical abuse and misuse.

(9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual

physicians, pharmacists, or recipients.

(10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.

(11) The research, development, and approval of a preferred drug list for:

(A) Medicaid's fee for service program;

(B) Medicaid's primary care case management program; and

(C) the primary care case management component of the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

(12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint commission on Medicaid oversight established by IC 2-5-26-3.

(14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

(15) Advising the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(11), the board shall do the following:

(1) Use literature abstracting technology.

(2) Use commonly accepted guidance principles of disease management.

(3) Develop therapeutic classifications for the preferred drug list.

(4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.

(5) Include in any cost effectiveness considerations the cost

implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(11) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration and that is:

(1) in a therapeutic classification:

(A) that has not been reviewed by the board; and

(B) for which prior authorization is not required; or

(2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list developed under subsection (a)(11):

(1) The office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:

(A) To override a prospective drug utilization review alert.

(B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.

(C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

(D) To permit implementation of a disease management program.

(E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

(h) At least two (2) times each year, the board shall provide a report to the select joint commission on Medicaid oversight established by IC 2-5-26-3. The report must contain the following information:

(1) The cost of administering the preferred drug list.

(2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.

(3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.

(4) The number of times prior authorization was requested, and the number of times prior authorization was:

(A) approved; and

(B) disapproved.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.".

Page 12, delete lines 23 through 42.

Delete pages 13 through 14.

Page 15, delete lines 1 through 17.

Page 15, line 21, delete "use the Medicaid preferred drug list developed under" and insert "**approve and implement chronic disease management and pharmaceutical management programs based on:**

(A) an analysis of the highest cost health care services covered under association policies;

(B) a review of chronic disease management and pharmaceutical management programs used in populations similar to insureds; and

(C) a determination of the chronic disease management and pharmaceutical management programs expected to best improve health outcomes in a cost effective manner;

(2) consider recommendations of the drug utilization review board established by IC 12-15-35-19 concerning chronic disease management and pharmaceutical management programs;

(3) when practicable, coordinate programs adopted under this section with comparable programs implemented by the state; and

(4) implement a copayment structure for prescription drugs covered under an association policy.

(b) A program approved and implemented under this section may not require prior authorization for a prescription drug that is prescribed for the treatment of:

(1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and is included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff); or

(2) hemophilia according to recommendations of the:

(A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or

(B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.".

Page 15, delete lines 22 through 27.

Page 15, line 28, delete "(b)" and insert "**(c)**".

Page 15, delete lines 30 through 35.

Page 15, line 36, delete "(b)" and insert "**(d)**".

Page 15, line 39, delete "(c)" and insert "**(e)**".

Page 16, line 3, delete "IC 27-8-10-3.7" and insert "IC 27-8-10-3.6".

Page 16, line 5, delete "3.7." and insert "**3.6.**".

Page 16, between lines 22 and 23, begin a new paragraph and insert:

"SECTION 10. IC 27-8-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a ~~five hundred dollar ($500)~~ deductible on a per person per policy year basis **in an amount that is:**

(1) equal to five hundred dollars ($500) for a policy year beginning in 2003; and

(2) determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

The deductible must be applied to the ~~first five hundred dollars ($500) of~~ eligible expenses, **other than prescription drug expenses, first** incurred by the covered person **during the policy year.**

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses, **other than prescription drug expenses,** by the insured in the form of deductibles and coinsurance may not exceed:

(1) one thousand five hundred dollars ($1,500) per individual or two thousand five hundred dollars ($2,500) per family, per policy year **for a policy year beginning in 2003; and**

(2) an amount that is determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.".

Page 16, line 25, delete "A person is not eligible for an".

Page 16, delete line 26.

Page 16, line 27, delete "(b)".

Page 16, run in lines 25 through 27.

Page 16, line 27, strike "subsections" and insert "**subsection**".

Page 16, line 27, reset in roman "(b)".

Page 16, line 27, after "(b)" insert ",".

Page 16, line 27, delete "(c)".

Page 16, line 27, strike "and".

Page 16, line 27, delete "(d),".

Page 16, line 34, reset in roman "(b)".

Page 16, line 34, delete "(c)".

Page 16, line 34, after "IC 27-13-16-4" insert ",".

Page 16, line 34, delete "and subsection (a),".

Page 17, line 16, delete "(d)" and insert "**(c)**".

Page 17, line 26, reset in roman "(d)".

Page 17, line 26, delete "(e)".

Page 17, line 42, reset in roman "(e)".

Page 17, line 42, delete "(f)".

Page 18, line 13, reset in roman "(f)".

Page 18, line 13, delete "(g)".

Page 18, line 13, reset in roman "(g),".

Page 18, line 13, delete "(h),".

Page 18, line 22, reset in roman "(g)".

Page 18, line 22, delete "(h)".

Page 18, line 25, reset in roman "(b),".

Page 18, line 25 delete "(c),".

Page 18, line 33, reset in roman "(h)".

Page 18, line 33, delete "(i)".

Page 19, line 27, delete "(a)".

Page 19, line 27, delete "IC 27-8-10-3.5," and insert "**IC 27-8-10-3.5 and**".

Page 19, line 28, delete "and IC 27-8-10-3.7, all" and insert "**both**".

Page 19, delete lines 32 through 38.

Renumber all SECTIONS consecutively.

(Reference is to HB 1749 as reprinted February 27, 2003.)

and when so amended that said bill do pass.

Committee Vote: Yeas 9, Nays 0.

Miller **Chairperson**